Fibromyalgia

Purpose

Fibromyalgia is a complex pain disorder that raises many questions for providers, particularly as to whether this condition is related to the industrial insurance system. The purpose of this bulletin is to answer a few of those questions:

- Is fibromyalgia accepted as an industrial injury or occupational disease?
- If a provider asserts a worker's fibromyalgia is related to the industrial injury or occupational exposure, what type of documentation should be submitted to support this contention?
- Will the department or self-insurer pay for short-term treatment of fibromyalgia?

Is fibromyalgia accepted as an industrial injury or occupational disease?

The Office of the Medical Director at the Department of Labor & Industries, in collaboration with the Washington State Medical Association's Industrial Insurance Guideline Subcommittee, studied fibromyalgia and the medical literature that addresses the causes of fibromyalgia. After careful consideration, it was determined that there is not sufficient medical data at this time to establish a causal relationship between an industrial injury or occupational exposure and the subsequent development of fibromyalgia.

Based on this lack of scientific evidence, the department does not generally recognize fibromyalgia as an industrial injury, an occupational disease, or an aggravation to a pre-existing condition.

The worker's health care provider may submit additional information, as described below, that the provider believes rebuts, or challenges, this general policy for an individual worker.

Reference: Provider Bulletin 98–11; Date Introduced: November 1998

If a provider asserts a worker's fibromyalgia is related to the industrial injury or occupational exposure, what type of documentation should be submitted to support this contention?

A provider who feels that a worker's fibromyalgia is causally related to an industrial injury or occupational disease is encouraged to submit additional information to support that diagnosis. The kinds of information useful in this regard include:

1. **Case-specific information linking the injury to the occurrence of fibromyalgia,**
   Case-specific information might include, but is not limited to:
   - Evidence of a temporal relationship to the worker's industrial injury or occupational exposure (e.g. the injury precedes all symptoms of fibromyalgia or symptoms of potentially crossover disorders such as chronic fatigue syndrome),
   - Documentation that the worker's diagnosis of fibromyalgia meets the American College of Rheumatology's 1990 Criteria for the Classification of Fibromyalgia (see attachment),
   - A biological and clinically justifiable rationale for the relationship between the industrial injury and the occurrence of fibromyalgia. The biological rationale should include a discussion based on accepted principles of biological sciences (anatomy, physiology, biochemistry, etc.) as to how the industrial injury caused the condition.

2. **Scientific studies that address the relationship between individual injuries and the occurrence of fibromyalgia.**
   The provider is encouraged to submit published scientific studies supporting the contention of causality. In 1996, and again in 1997 and 1998, the department reviewed the existing scientific literature on this subject and found insufficient medical data to establish a causal relationship between a traumatic injury or occupational exposure and the development of fibromyalgia. Therefore, it is particularly important that the provider point out any new studies or new analyses of old studies that he or she feels supports a different conclusion regarding causality.

Effective January 1, 1999, State Fund claim managers will automatically request this information from the attending physician whenever fibromyalgia is contended on a claim. Information submitted by the provider to support the causal relationship will be reviewed by department medical staff before a claim adjudication decision is made.

Will the department or self-insurer pay for short-term treatment of fibromyalgia?

Temporary treatment as an aid to recovery

In general, fibromyalgia is not an accepted condition and treatment is not allowed. However, if fibromyalgia is directly retarding recovery of the accepted industrial injury or occupational disease, the department or self-insurer may authorize temporary treatment per WAC 296-20-055. Temporary treatment can be authorized when all of the following conditions are met:

- The accepted industrial injury is not stable,
- Fibromyalgia is directly retarding recovery of the accepted industrial injury or occupational disease, and
- The required documentation is submitted (see authorization and documentation requirements below).

Treatment as an aid to recovery will be authorized for no longer than 90 calendar days. If the worker has reached maximum recovery from the accepted industrial injury or occupational disease prior to the 90-day period, the fibromyalgia treatment will be terminated at that time.

What are the authorization requirements?
The provider must obtain prior authorization to treat fibromyalgia as an aid to recovery. The department or self-insurer will not pay for treatment for fibromyalgia as an unrelated condition unless specifically authorized.

To request prior authorization, the provider must submit the following in writing to the department or self-insurer:
- Adequate documentation that the worker's diagnosis of fibromyalgia meets the American College of Rheumatology's (ACR) 1990 Criteria for the Classification of Fibromyalgia (see attachment A),
- An explanation of how fibromyalgia, as an unrelated condition, is affecting the accepted industrial condition, and
- A treatment plan.

Note: The State Fund's Provider Toll Free staff will not be able to authorize these services.

What type of treatment may be allowed for the temporary treatment of fibromyalgia?
The department or self-insured employer is most likely to approve treatment plans that include conservative, non-invasive treatment that the scientific literature has shown to be effective in the short term. Such treatment includes, but may not be limited to:
- Physical therapy,
- Low dose tricyclic anti-depressants,
- Muscle relaxants on a time-limited basis, or
- Spinal manipulations.

The department or self-insured employer will **not** approve invasive therapies or treatments whose effectiveness has not been documented for even the short-term. The following types of treatment will not be approved for the treatment of fibromyalgia:

- Trigger point injections,
- Methotrexate,
- Opioids, or
- NSAIDS.

Note: Fibromyalgia may coexist with other conditions for which such therapies may be indicated.

What are the documentation requirements?
When treating an unrelated condition, the attending physician must submit a report every 30 days outlining the effect of the treatment on both the unrelated and the accepted industrial conditions.

Because fibromyalgia does not have a unique diagnosis code, we ask that providers use ICD.9 code 729.1 (myalgia) on bills submitted for treatment of fibromyalgia.

Where is more information available?

Temporary treatment of unrelated conditions when retarding recovery
WAC 296-20-055

Criteria for the classification of fibromyalgia
- Enclosed summary, attachment A.
- Frederick Wolfe, et.al., "The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia, Report of the Multicenter Criteria Committee," *Arthritis and Rheumatism*, Vol. 33, No. 2, (February 1990).

ATTACHMENT A

The American College of Rheumatology's 1990 Criteria for the Classification of Fibromyalgia*

For classification purposes, patients will be said to have fibromyalgia if both criteria are satisfied. Widespread pain must have been present for at least 3 months. The presence of a second clinical disorder does not exclude the diagnosis of fibromyalgia.

1. **History of widespread pain.**

   Pain is considered widespread when all of the following are present: pain in the left side of the body, pain in the right side of the body, pain above the waist, and pain below the waist. In addition, axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) must be present. In this definition, shoulder and buttock pain is considered as pain for each involved side. "Low back" pain is considered lower segment pain.

2. **Pain, on digital palpation, must be present in at least 11 of the following 18 tender point sites:**

   Occiput - bilateral, at the suboccipital muscle insertions
   Low cervical - bilateral, at the anterior aspects of the intertransverse spaces at C5-C7
   Trapezius - bilateral, at the midpoint of the upper border
   Supraspinatus - bilateral, at origins, above the scapula spine near the medial border
   Second rib - bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces
   Lateral epicondyle - bilateral, 2 cm distal to the epicondyles
   Gluteal - bilateral, in upper outer quadrants of buttocks in anterior fold of muscle
   Greater trochanter - bilateral, posterior to the trochanteric prominence
   Knee - bilateral, at the medial fat pad proximal to the joint line

   Digital palpation should be performed with an approximate force of 4 kg. For a tender point to be considered "positive" the subject must state that the palpation was painful. "Tender" is not to be considered "painful".

* Frederick Wolfe, et.al., "The American College of Rheumatology 1990 Criteria for the Classification of Fibromyalgia, Report of the Multicenter Criteria Committee", Arthritis and Rheumatism, Vol. 33, No. 2 (February 1990)

Guidelines for Outpatient Prescription of Controlled Substances, Schedules II-IV, For Workers on Time-Loss

L&I, in collaboration with the Washington State Medical Association, has developed two guidelines on the topic of opioids and controlled substances. These two guidelines have some areas of overlap, and some content found in one but not the other guideline. Therefore, both guidelines are included in this publication.

On the following pages you will find the first of the two guidelines, developed in 1992. The second guideline, dealing with opioids, is located in a separate section.

Below is a table summarizing some of the differences between the two guidelines.

It is hoped that clinicians will find both guidelines helpful, depending on the circumstances of each individual patient.

1992 Guideline on Controlled Substances	2000 Guideline on Opioids
• Relates to all controlled substances, not just opioids	• Relates primarily to opioids
• Deals with treatment in the acute and subacute phases	• Deals primarily with chronic phase
• Includes special tools helpful to clinicians, such as: ❑ A useful chart listing examples of Schedule II, III, and IV controlled substances ❑ A list of relative contraindications for the use of controlled substances ❑ 3 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in *Attending Doctor's Handbook* ❑ Handy patient education sheet, with a message from the Washington State Medical Association	• Includes special tools helpful to clinicians, such as: ❑ Sample Opioid Treatment Agreement ❑ Functional Progress Form (optional) ❑ Opioid Progress Report (required) ❑ 2 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in Provider Bulletin 00-04 ❑ Billing information so providers may be reimbursed for services described
• Includes a guideline only, with no absolute requirements in regulation or law	• Includes the guideline, accompanied by regulations (WACs) and the 1998 Guideline from the Department of Health

Guidelines For Outpatient Prescription Of Controlled Substances, Schedules II-IV, For Workers On Time-Loss

Developed by the Washington State Medical Association and the Washington State Department of Labor and Industries.
Adopted 1992 by the Washington State Medical Association Industrial Insurance and Rehabilitation Committee

INTRODUCTION

Purpose of the Guidelines

Repeated, long-term use of prescription controlled substances for chronic nonmalignant pain may be a factor in the development of long-term disability. This condition may be preventable if at-risk patients and practices are proactively identified and managed appropriately.

It is hoped that the prescribing guidelines listed below will lead to more accurate and timely identification of workers at risk for the development of long-term disability. These guidelines may also be a component of future intervention strategies aimed at preventing long-term disability.

Development of the Guidelines

These guidelines were developed by the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee and the Washington State Department of Labor and Industries. They are based on information from existing prescription guidelines, literature reviews, pharmacologic and medical references, seminars, interviews of experts, and consultations with physicians who have private practices in a wide variety of specialties.

Application of the Guidelines

The guidelines are intended for use in the management of chronic nonmalignant pain. Chronic nonmalignant pain is defined as pain persisting beyond the expected normal healing time for an injury, for which traditional medical approaches have been unsuccessful. Application of these guidelines is intended only for outpatient prescriptions of nonparenteral controlled substances. The nonparenteral routes of administration are considered the only acceptable routes for treating chronic nonmalignant pain in the Washington state workers' compensation system (WAC 296-20-03014).

It is recognized that the guidelines cannot apply uniformly to every patient. Also, the guidelines cannot be the sole determining basis for identifying patients at risk for a drug use problem or currently experiencing a drug use problem. Mere application of the guidelines cannot substitute for a thorough assessment of the patient or medical file by qualified health care professionals. For example, it may be acceptable to prescribe opioids to workers who are gainfully employed and not receiving time-loss. Similarly, the guidelines cannot substitute for detailed prescribing information found in many medical and pharmacologic references.

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Date Introduced: 1992

These guidelines will be applied in the workers' compensation setting only. The guidelines will apply only to workers whose injuries occurred after the guidelines are adopted by WSMA and sufficient notice has been given to providers. ***The Department of Labor and Industries may impose sanctions if the guidelines are not followed.***

The guidelines are intended for use by physicians who begin treatment within 6 months of the worker's injury. Patients who have been on controlled substances for prolonged periods and come under the care of a new physician present special problems. These and other problems will be dealt with in a separate publication.

Finally, while the guidelines may not conflict with state or federal laws, by necessity they cannot cover in detail all of the many rules, regulations, and policies published by the various agencies enacting and enforcing these laws.

Table 1

Documentation Recommendations When Controlled Substances Are Prescribed

a. A thorough medical history and physical examination and medical decision-making plan should be documented, with particular attention focused on determining the cause(s) of the patient's pain.

b. A written treatment plan should be documented and should include the following information:
   * a finite treatment plan that does not exceed six weeks.
   * clearly stated, measurable objectives.
   * a list of all current medications (with doses) including medications prescribed by other physicians (whenever possible).
   * description of reported pain relief from each medication.
   * justification of the continued use of controlled substances.
   * documentation of attempts at weaning.
   * explanation of why weaning attempts have failed (including detailed history to elicit information on alcohol and drug use).
   * how the patient's response to medication will be assessed.
   * further planned diagnostic evaluation.
   * alternative treatments under consideration.

c. The risks and benefits of prescribed medications should be explained to the patient and the explanation should be documented, along with expected outcomes, duration of treatment, and prescribing limitations.

d. The treatment plan should be revised as new information develops which alters the plan.

Table 2

Relative Contraindications For The Use Of Controlled Substances

1.	*History* of alcohol or other substance abuse, or a history or chronic, high dose of benzodiazepine use.
2.	*Active* alcohol or other substance abuse.
3.	*Borderline* personality disorders.
4.	*Mood disorders* (e.g., depression) or psychotic disorders.
5.	*Other* disorders that are primarily depressive in nature.
6.	*Off work* for more than 6 months.
*	Note: When special circumstances seem to warrant the use of these drugs in the types of patients noted above, referral for review is indicated.

General Information

A. Please refer to the "Introduction" for more information on the purpose, development, and application of these guidelines

PHYSICIANS MAY BE HELD ACCOUNTABLE IF THEIR PRESCRIBING PATTERNS FALL OUTSIDE THESE GUIDELINES.

B. Documentation recommendations (as presented in Table 1) should be followed at all times, especially whenever the physician departs from the guidelines listed below.

TREATMENT OF ACUTE PAIN FROM TRAUMATIC INJURIES OR SURGERY (POST-DISCHARGE):

A. Schedule II drugs should be prescribed for no longer than 2 weeks.

B. Schedule III and Schedule IV drugs should be prescribed for no longer than 6 weeks. (See Table 3 for examples of controlled substances.)

TREATMENT OF CHRONIC NON-MALIGNANT PAIN*:

A. **EXTREME CAUTION** should be used in prescribing controlled substances for workers with one or more "Relative Contraindications" (see Table 2). (NOTE: When special circumstances seem to warrant the use of these drugs in the types of patients listed in Table 2, referral for review is indicated.)

B. For patients on a **combination** of opioids and scheduled sedatives:

TREATMENT WITH COMBINATIONS SHOULD USUALLY NOT EXTEND BEYOND 6 WEEKS.

C. For patients on opioids **OR** scheduled sedatives (but not combinations of the two):

TREATMENT SHOULD USUALLY NOT EXTEND BEYOND 3 MONTHS.

D. Consultation or referral to a chronic pain specialist should be considered when any of the following conditions exist:

1. underlying tissue pathology is minimal or absent, **AND** correlation between the structural derangement caused by the original injury and the severity of impairment is not clear;

2. suffering and pain behaviors are present, and the patient continues to request medication; or

3. standard treatment measures have not been successful or are not indicated.

* Defined as pain persisting beyond the expected healing time for an injury, for which traditional medical approaches have been unsuccessful.

Table 3

Examples Of Controlled Substances*

SCHEDULE II	SCHEDULE III	SCHEDULE IV
OPIOIDS: codeine fentanyl (Sublimaze, Innovar) hydromorphone (Dilaudid) levorphanol (Levo-Dromoran) meperidine (Demerol) meperidine w/ Promethazine (Mepergan) methadone (Dolophine) morphine (MS Contin, MSIR, OMS, RMS, Roxanol) oxycodone oxycodone w/ acetaminophen/aspirin (Percocet, Percodan, Roxicet, Roxiprin, Tylox)	OPIOIDS: acetaminophen with codeine (Codalan, Phenaphen 2, 3, 4, Tylenol 2, 3, 4) aspirin with codeine (Empirin 2, 3, 4) hydrocodone hydrocodone w/ acetaminophen/aspirin (Anexsia, Azdone, Bancap, Co-gesic, Damason-P, Dolacet, Duocet, Endal-HD, Hyco-Pap, Hydrocet, Hyphen, Lorcet Plus, Lorcet HD, Lortab, Vicodin, Zydone) nalorphine paregoric	OPIOIDS: propoxyphene (Darvon) propoxyphene w/ acetaminophen/aspirin (Darvocet, Dolene, Wygesic) pentazocine (Talwin)
SEDATIVES: amobarbital (Amytal)** secobarbital (Seconal)** pentobarbital (Nembutal)**	SEDATIVES: any compound containing an unscheduled drug and: amobarbital ** secobarbital** pentobarbital** glutethimide (Doriden) Non-narcotic Analgesic Combinations butalbital with acetaminophen/aspirin (fiorinal)	SEDATIVES: chloral hydrate clorazepate (Tranxene) chlordiazepoxide (Librium) clonazepam (Klonopin) diazepam (Valium) ethchlorvynol (Placidyl) flurazepam (Dalmane) meprobamate (Equanil, Miltown) oxazepam (Serax) paraldehyde (Paral) phenobarbital ** prazepam (Centrax) triazolam (Halcion)

* This table is not intended as an exhaustive listing of controlled substances. A few trade names have been given as examples. This listing should in no way be construed as an endorsement of any medication.

** Barbiturates are not paid for by the Department at any time (except phenobarbital, which is allowed only for seizure disorders).

TO OUR PATIENTS

WHAT YOU SHOULD KNOW ABOUT RULES YOUR DOCTOR MUST FOLLOW TO PRESCRIBE DRUGS THAT MAY BE ADDICTIVE.

The Washington State Medical Association (WSMA) and the Department of Labor and Industries (L&I) believe that it may do you more harm than good to take addicting drugs for a long time.

Guidelines approved by the Washington State Medical Association must be followed by your physician.

SO PLEASE HELP YOUR PHYSICIAN TO HELP YOU -- FOLLOW YOUR DOCTOR'S INSTRUCTIONS CAREFULLY.

THANK YOU!

A message from the Washington State Medical Association.

To the doctor: Please feel free to photocopy this sheet and distribute to your patient, preferably along with your first prescription for controlled substance.

Selected References

The following are a few of the published materials used to prepare these guidelines.

AHFS Drug Information '91, American Hospital Formulary Service, by the American Society of Hospital Pharmacists, Inc., Bethesda, MD, 1991.

"Chronic Opioid Therapy in Nonmalignant Pain," RK Portenoy, Journal of Pain and Symptom Management, Vol. 5, No. 1 (Suppl.) February 1990, pp. S46-S62.

Guidelines for Prescribing Controlled Substances for Chronic Conditions, California Medical Association, San Francisco, CA, April 12, 1985.

"Medications in Low Back Pain," JP Robinson and PB Brown, Physical Medicine and Rehabilitation Clinics of North America, Vol. 2, No. 1, February 1991, pp. 97-125.

"Prescribing Practices for Pain in Drug Dependence: A Lesson in Ignorance," LM Halpern and JP Robinson, Controversies in Alcoholism and Substance Abuse, The Haworth Press, Inc., 1986.

"Unlocking the Secrets of Pain — The Treatment — A New Era," JD Loeser, Medical and Health Annual Encyclopedia Britannica, 1988 pp 120-31.